

## National Health Law Program

### Docket of Medicaid Cases to Improve Dental Access

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This memorandum provides an annotated listing of Medicaid dental provider participation cases. It does not address the hundreds of cases involving the amount, duration and scope of dental services.

#### *Snapshot of findings:*

We located a total of 26 cases, from 21 jurisdictions: Arkansas, California, Connecticut, District of Columbia, Florida, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, and West Virginia.

The complaints in these cases cite a number of Medicaid Act provisions but focus on the following:

- 42 U.S.C. § 1396a(a)(8) (the “reasonable promptness” requirement that Medicaid to be provided with reasonable promptness)
- 42 U.S.C. § 1396a(a)(30)(A) (the “equal access” requirement that payments to be consistent with efficiency, economy, quality of care and assure equal access)
- 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r) (the “EPSDT” requirement for comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children and youth under age 21) and implementing regulations, e.g. 42 C.F.R. § 441.61(b) (requiring states to “make available a variety of individual and group providers”)

Most cases have settled without a trial. The settlements typically address payment rates and include provisions to address other barriers, such as claims processing, transportation, and lack of awareness among beneficiaries of the availability of dental services through Medicaid. Recently, states have challenged the plaintiffs’ right to enforce the Medicaid Act and/or refused to negotiate, thus requiring the issues to be decided by a trial.

#### OTHER OFFICES

Annotated case listing:<sup>1</sup>

## Arkansas

*Arkansas Medical Society v. Reynolds*, 819 F. Supp. 816 (E.D. Ark. 1993), *aff'd*, 6 F.3d 519 (8th Cir. 1993)

**Background:** This case challenged an across-the-board plan to reduce outpatient reimbursement rates, including those paid to dentists. The Court found the reduction to violate the Medicaid equal access requirement, 42 U.S.C. § 1396a(a)(30)(A).

**Outcome:** The Medicaid agency was ordered to revise its reimbursement plan within 120 days by removing the reduction. While the rate issue was resolved, this case has become a leading case for the ability of Medicaid providers and beneficiaries to enforce the equal access provision of the Medicaid Act in court.

## California

\**Clark v. Kizer*, 758 F. Supp. 572 (E.D. Cal. 1990), *aff'd in part & vacated in part sub nom. Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992), *on remand*, No. S-87-1700LKK, 1992 WL 370801 (E.D. Cal. 1993), *aff'd in part & remanded in part*, 8 F.3d 26 (9th Cir. 1993), *related references*, 66 F.3d 334 (9th Cir. 1995), *vacating*, 1994 WL 764117 (E.D. Cal., Dec. 13, 1994) (regarding legislation affecting adult eligibility), 60 F.3d 600 (9th Cir. 1995), *rev'g*, 1993 WL 720217 (E.D. Cal., Dec. 17, 1993), *related references*, 1989 WL 265478 (E.D. Cal., Nov. 3, 1989) (settlement regarding availability of obstetrical care providers), 1988 WL 235548 (E.D. Cal., May 9, 1988) (dismissing third party complaint against Secretary of US Department of Health and Human Services)

**Background:** This case was brought on behalf of women needing obstetrical care and beneficiaries needing dental services. The obstetrical part of the case settled early on, following a rate increase. The Court held the state Medicaid agency violated 42 U.S.C. § 1396a(a)(30)(A), when it maintained a dental reimbursement fee schedule that did not ensure that Medicaid beneficiaries have access to dental services at least to the extent that the general population has access to these services. The *Clark* court was persuaded by the fact that “the present rates are not even adequate to meet overhead, let alone allowing for some marginal profit.” 758 F. Supp. at 577. Other Medicaid violations included § 1396a(a)(1) (statewideness) and § 1396a(a)(10) (comparability).

**Outcome:** The Medicaid agency was ordered to increase rates to 80% of UCR (Usual Customary and Reasonable) rates for 56 commonly performed procedure codes and to provide annual cost of living adjustments.

At the time *Clark* was filed, about 30% of Medicaid beneficiaries visited a dentist at least once a year. Following entry of the compliance plan in 1994, the Medicaid utilization rate reached 46% by 1998 (Source: DHS Compliance Reporting).

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<sup>1</sup> The National Health Law Program represents the plaintiffs in cases marked with an asterisk.

In the late 1990s, the court ordered the state to submit a plan for increasing utilization in 16 under-served counties. Under the approved plan, the state would increase utilization to at least 41.7%.

Note: This is the first dental provider participation case to challenge rates as inadequate (as opposed to challenging a reduction in rates). In finding a violation of the equal access provision, the district court applied a multi-factor approach that has been cited approvingly by subsequent courts. The two major factors considered by the *Clark* court were the level of dental participation in the Medicaid program and the level of reimbursement to participating providers. In addition, the court considered: whether providers are widely opting out of Medicaid or restricting their Medicaid caseloads; whether there is a steady stream of reports that recipients are having difficulty obtaining care; and admissions by state agency personnel that reimbursement rates are inadequate. The *Clark* court also looked to the utilization rate as a factor that may be considered, but noted that this factor was not dispositive.

### Connecticut

*Carr v. Wilson-Coker*, Civ. No. 3:00CV01050 (D. Conn. Jan. 27, 2006)

Background: Medicaid beneficiaries (adults and children) filed this class action lawsuit in 2000, alleging that the Connecticut Department of Social Services had not administered or funded its managed care program to attract an adequate number of dentists as required by federal law. Among other things, the plaintiffs alleged that dental screening had shown decreasing utilization.

Outcome: The Court dismissed a number of the plaintiffs' claims, including an equal access claim. In 2006, the Court focused on the EPSDT claim. It noted federal Medicaid goals for 80% utilization and found the State to have fallen short of the goal. The Court also found it "compelling" that children had to wait for substantial periods of time and travel outside of their local areas to find a dentist. However, the Court found these cases did not show that EPSDT dental services are not provided but rather that they are not provided within a reasonable time at a convenient location. The Court found there were material issues in dispute and ordered the case to proceed toward trial.

### District of Columbia

\**Salazar v. District of Columbia*, No. CA-93-452 (GK), (Jan. 25, 1999) (Consent judgment; Order modifying amended remedial order); 1997 WL 306876 (D.D.C., Jan. 17, 1997) (Remedial order), *earlier case history*, 938 F. Supp. 926 (D.D.C.), *amended and superceded by*, 954 F. Supp. 278 (D.D.C. 1996), *same case*, *Wellington v. District of Columbia*, 851 F. Supp. 1 (D.D.C. 1994) (allowing private enforcement of Medicaid Act)

Background: Plaintiffs are a class of poor children, including those with special health care needs and those with limited English proficiency.

Outcome: In 1996, the Court found that the District of Columbia violated EPSDT laws when it failed to assure that children were receiving screening and treatment services, including dental services, in either fee-for-service or managed care organizations (MCOs). See 954 F. Supp. at 328 (ordering the District to “design and employ policies and methods to assure that children receive screening and treatment when due.”) In 1997, the parties entered into a consent judgment. The District agreed to engage in extensive outreach and informing of Medicaid families regarding the scope of EPSDT services and to monitor MCOs to assure that contracted services actually are being delivered. The parties also agreed that MCOs would develop and implement corrective action plans for problematic plans and that financial penalties could be imposed for noncompliance. All of the MCOs have developed corrective action plans to improve the delivery of oral health services.

In 2004, the plaintiffs filed a motion for enforcement, using data reported by the District and the MCOs showing that utilization of dental services was quite low. The Court entered further injunctive relief on October 18, 2004, ordering the District to make progress with rate increases, to increase utilization and to assure that services were available system-wide, including to children with limited-English proficiency. The Court ordered the District, by September 30, 2007, to show that:

- (a) at least 80% of EPSDT-eligible children three-years old and older receive a dental service in the previous 12 months;
- (b) 85% of school-age children receive an oral health screening by a dentist upon entering school for the first time; and
- (c) 70% of all 8-14 year-old children receive protective sealants on their permanent teeth.

On May 26, 2006, the District filed a motion asking for the dental injunction to be lifted, and that motion is currently being briefed by the parties. Meanwhile, the Court monitor is meeting with the parties and area dentists to better understand the barriers to access, and MCOs continue to submit corrective action plans.

#### Florida

*Florida Pediatric Society/The Florida Chapter of the American Academy of Pediatrics v. Levine*, No. 05-23037-CIV-HUCK (S. D. Fla., filed Nov. 21, 2005).

The State has made a motion to dismiss, arguing that the provider groups cannot privately enforce the federal Medicaid law, including the equal access, EPSDT, and reasonable promptness requirements.

#### Illinois

*Memisovski v. Maram*, No. 92 C 1982, 2004 U.S. Dist. LEXIS 16772 (N.D. Ill., Aug. 23, 2004)

Background: This case was filed by children in Cook County, Illinois who complained about the lack of access to Medicaid services, including dental services.

Outcome: The Court found violations of the equal access and EPSDT requirements. Regarding dental care, the Court found that dentists limit the number of Medicaid patients they will see because their practices would fail financially if they accepted all Medicaid patients who presented themselves for treatment. The Court found that 75% of children did not obtain a dental screen. Following the ruling, the State:

- (a) increased rates for dental codes for the basic office services for preventive dentistry (checkup, cleaning, prophylaxis), roughly doubling the old rate and bringing these codes into parity with the state employees health plan; and
- (b) initiated a study of access to specialty care (including dental) that should evidence any further problems.

## Indiana

*Bond v. Stanton*, 630 F.2d 1231 (1980), *appeal after remand*, 655 F.2d 766 (7th Cir.) (EPSDT screening, identification of providers, and follow up), *same case*, 372 F. Supp. 872 (N.D. Ind. 1974), *aff'd*, 504 F.2d 1246 (7th Cir.)

Background: The case was filed by Medicaid-eligible children.

Outcome: The Seventh Circuit decided: "Indiana's somewhat casual approach to EPSDT hardly conforms to the aggressive search for early detection of child health problems envisaged by congress.... EPSDT programs must be brought to the recipients; the recipients will not ordinarily go to the programs until it is too late to accomplish the congressional purpose." 504 F.2d at 1251.

The state was required to provide guidance to providers as to what services are covered under EPSDT, including dental screens and to engage in aggressive outreach to inform beneficiaries of these services.

## Kentucky

*Greer v. Childress*, No. 95-CV-11 (E.D. Ky.) (Voluntary dismissal, March 1995)

This case was filed by the Kentucky Dental Association (KDA) in 1994, after the state Medicaid agency reduced dental reimbursement rates. The suit was dismissed after the state Medicaid agency raised rates, erasing the reduction.

## Maine

\**Spencer v. Concannon*, Civ. No. 97-197-B-C (D. Me.) (Agreed order of dismissal, Apr. 27, 1998)

Background: The Medicaid beneficiaries' complaint in this case claimed violations of § 1396a(a)(30) (equal access), § 1396a(a)(1) (statewideness), § a(a)(8) (reasonable

promptness), § a(a)(10)(B) (comparability in the provision of services), and §§ a(a)(43), d(a)(4)(B), and d(r) (EPSDT).

Outcome: The case settled when the state Medicaid agency agreed to:

- (a) increase payment rates;
- (b) engage in an educational campaign to increase provider participation;
- (c) revise the dental claim form;
- (d) provide toll-free telephone assistance to refer beneficiaries to dentists;
- (e) monitor provider participation and beneficiary utilization of dental services;
- and
- (f) arrange dental services for the named plaintiffs, including entering into private pay arrangements if necessary.

### Massachusetts

*Health Care for All v. Romney*, Civ. No. 1:00-CV-10833-RWZ, 2005 U.S. Dist. LEXIS 14187 (D. Mass., July 14, 2005)

Background: The class action case, filed by Medicaid beneficiaries in July 2000, alleged that the state Medicaid agency failed to provide adequate oral health services to members of the MassHealth Medicaid program. A number of Medicaid Act violations were alleged: 42 U.S.C. § 1396a(a)(1) (statewideness), § a(a)(8) (reasonable promptness), § a(a)(10)(B) (comparability), § a(a)(30) (quality and equal access), and § a(a)(43) (EPSDT).

Outcome: The Court held that Massachusetts' low Medicaid payment rates for dentists significantly contributed to a lack of available providers for children, but not for adults. The Court found a violation of the reasonable promptness requirement regarding children's services, stating: "Setting reimbursement levels so low that private dentists cannot afford to treat Medicaid enrollees effectively frustrates the reasonable promptness provision by foreclosing the opportunity for enrollees to receive medical assistance at all, much less in a timely manner."

The Court found that inadequate access also violated the EPSDT requirements. The Court noted that its holding did not rely on the equal access requirement (which it had earlier held could not be privately enforced). Instead, the judge relied on the evidence of inadequate and inaccurate materials about EPSDT dental services, the high volume of customer complaints, and the "shockingly low" number of children enrolled in Medicaid versus children enrolled in private insurance who received dental services.

The Court entered a Joint Remedial Plan agreed to by the parties on February 3, 2006 which includes:

- (a) a program of member assistance, which includes assistance in making and keeping appointments and with transportation;

- (b) developing and maintaining a provider network, including instituting a practice of contacting any provider announcing intent to withdraw from Medicaid and attempting to discover why and to convince them not to do so;
- (c) appropriations in FY 2007 to increase reimbursement rates using the most current and accurate data available, followed by annual assessment of whether further increases are needed;
- (d) instituting a practice of sending information about dental services at six month intervals, 60 days after eligibility determinations and re-determinations, and sending targeted information to individuals for whom there has been no Medicaid claim in the past year;
- (e) authorizing the State to proceed with implementing a state law that allows dentists to limit the number of MassHealth patients in their practices; and
- (f) appointing an independent monitor to assess implementation and effectiveness of the remedial program, including measuring the receipt of: dental sealants, dental screenings, dental prophylaxis, fluoride treatment and restorative care.

### Michigan

\**Westside Mothers v. Haveman*, 368 F. Supp. 2d 740 (E.D. Mich. 2005) (on appeal), *same case*, 289 F.3d 852 (6th Cir. 2002) (denying motion to dismiss), *rev'g in part and aff'g in part*, 133 F. Supp. 2d 549 (E.D. Mich. 2001)

Background: This case was filed by parents and pediatric providers of children who are experiencing difficulties accessing EPSDT services, including dental care. The case includes claims based on § 1396a(a)(30)(A) (equal access), § a(a)(8) (reasonable promptness), and § 1396u-2(b)(5) (adequate number, mix, and geographic distribution of managed care providers), and EPSDT provisions.

Outcome: The most recent district court ruling, in 2005, held that the reasonable promptness and EPSDT-related provisions could be enforced by the plaintiffs but the equal access requirement could not. The Court also held that the plaintiffs had not proven their claims because it decided that “medical assistance” under the Medicaid Act does not include the provision of medical services but only payments; nor does it include a right to force the State to ensure 100% participation by all potentially eligible individuals. The case has been appealed and argued and is awaiting decision from the Sixth Circuit Court of Appeals.

### New Hampshire

*Hawkins v. Commissioner*, No. C-99-143-JD, 2004 DNH 23 (D.N.H. 2004)

Background: This class action case was filed by a parent on behalf of her Medicaid-eligible children in 1999. A number of Medicaid Act violations were alleged, including: 42 U.S.C. § 1396a(a)(43) (inform beneficiaries of EPSDT benefits), 42 C.F.R. § 441.62 (provide transportation and appointment scheduling assistance), § 1396a(a)(43)(B) and 1396d(r) (provide or arrange for dental screening services and needed treatment, including case management and transportation services), §

1396a(a)(30)(A) (equal access), § 1396a(a)(1) (statewideness), and § 1396a(a)(8) (reasonable promptness).

Outcome: The case settled in early 2004. The consent decree contemplates a five-to-six year period of court jurisdiction overseeing implementation. Among other things, the State agreed to:

- (a) allocate \$1.2 million each year in additional state funds for the EPSDT dental program;
- (b) maintain dedicated toll-free numbers for individuals to obtain information;
- (c) arrange for periodic dental screening, beginning at age three (or earlier upon physician referral);
- (d) establish a procedure for providing scheduling assistance, to include referrals to specific dentists;
- (e) periodic written and oral informing of recipients of EPSDT and the need for dental care, to include targeted outreach to non-users;
- (f) provide transportation to dental appointments; and
- (g) provide data and reports on program measures, including the number of children, by age group, using sealants, preventive services, dental visits, topical fluoride, and a dental home (defined as at least three examinations under continuous enrollment).

*Swain v. Gregg*, Civ. No. 90-91-D (D.N.H.) (Consent decree, May 5, 1991)

Background: The plaintiffs claimed dental payment rates were too low.

Outcome: The parties settled this case when the state agreed to:

- (a) increase dental reimbursement rates;
- (b) review the adequacy of rates annually;
- (c) make needed adjustments to rates;
- (d) update its periodicity schedule for dental screening under EPSDT,
- (e) use “pay and chase,” rather than “cost avoidance,” third party liability collection practices when dealing with EPSDT claims; and
- (f) engage in regular contact and meetings with the New Hampshire Dental Society to resolve problems early and encourage provider participation in Medicaid.

## New Jersey

*Pelletier v. Waldman*, Civ. No. 2:93-cv-02488-HAA (D.N.J.) (Voluntary dismissal, April 21, 1995)

The complaint in this case, filed on June 9, 1993, alleged that the State was violating mandatory EPSDT provisions by failing to provide preventive dental services to children. Claims for relief included: 42 U.S.C. § 1396a(a)(1) (statewideness), § a(a)(8) (reasonable promptness), § a(a)(10)(B) (comparability), § 1396a(a)(23) (free choice of providers), § a(a)(30) (quality and equal access), § a(a)(37) (prompt and efficient

claims payment), and §§ a(a)(43), d(a)(4)(B), d(r) (EPSDT). This case was dismissed following settlement; however, the terms of the agreement are not published or posted on electronic case filing systems.

## New York

*Dental Society of New York v. Pataki*, Civ. No. 99-C-0156 (N.D.N.Y.) (Stipulation, May 24, 2000)

Claims: This class action case was filed by the New York State Dental Association, individual dentists, and Medicaid beneficiaries in February 1999. It charged the state Medicaid agency with failure to adhere to 42 U.S.C. § 1396a(a)(1) (statewideness), § a(a)(8) (reasonable promptness), § a(a)(10)(B) (comparability), § a(a)(23) (free choice of providers), § a(a)(30) (quality care and equal access), and § a(a)(37) (prompt and efficient claims payment). Among other things, the complaint pointed out that dental rates had not increased appreciably from the inception of the Medicaid program in 1966.

Outcome: The parties entered a stipulated settlement on May 24, 2000. This agreement required dental expenditures to be increased each year for the next four years for selected service fees. In addition, a Medicaid Dental Advisory Committee would be established to make recommendations to the Medicaid agency for improving access (to sunset March 31, 2004).

*Dental Society of New York v. Carey*, 61 N.Y.2d 330, 462 N.E.2d 362, 474 N.Y.S.2d 262 (Ct. App. 1984)

This case challenged New York's dental rates as violating federal comparability and equal access regulations. The published decision deals with procedural challenges and does not address the substance of the case. The court held the Dental Society had standing to bring the case on behalf of its members and that the claims were within the court's competence to decide.

## North Carolina

\**Antrican v. Buell*, Civ. No. 4:00-CV-173-H (E.D.N.C.) (Settlement agreement, March 2003), *same case*, 158 F. Supp. 2d 663 (E.D.N.C. 2001), *aff'd*, 290 F.3d 178 (4th Cir. 2002) (denying motion to dismiss)

Background: This complaint was filed on behalf of Medicaid beneficiaries under age 21, who alleged that dental services were not adequately available and accessible. Some plaintiffs were traveling more than three hours, each way, to obtain dental care. Plaintiffs alleged violations of: 42 U.S.C. §§ 1396a(a)(43) and 1396d(r) (EPSDT benefits and informing), § 1396a(a)(30)(A) (equal access), § 1396a(a)(1) (statewideness), § 1396a(a)(8) (reasonable promptness), § 1396a(a)(23) (free choice of providers), and § 1396a(a)(10) (comparability).

Outcome: The parties settled the case in early 2003. The State agreed to:

- (a) increase payment rates to 73% of the UNC-Chapel Hill Dental Faculty Practice's UCR charges for 40 of the dental procedures most commonly provided to children;
- (b) establish a Medicaid Dental Advisory Committee, as part of the influential NC Physicians' Advisory Group;
- (c) provide written materials to beneficiaries regarding Medicaid dental services and the importance of dental care;
- (d) engage in targeted outreach to dentists, through newsletters and presentations at the UNC-Chapel Hill Dental School; and
- (e) provide toll-free telephone assistance to individuals seeking a dentist.

Preliminary evaluations suggest that increased rates have coincided with improved participation and utilization levels; for example, active dentist participation increased 33% between 2001 and 2004 (Mofidi 2005). The state legislature increased dental rates again in the 2005 biennium session. Legislation was introduced on May 24, 2006 (S. 1863) to further increase dental payment rates. While the UNC Faculty rates were supported by providers and the State in 2003, both groups have more recently discussed the potential benefits of a market-based fee schedule.

## Oklahoma

*Okla. Chptr. of the Am. Acad. of Pediatrics v. Fogarty*, 366 F. Supp. 2d 1050 (N.D. Okla. 2005) (on appeal)

**Background:** The plaintiffs are children who alleged a lack of equal access to child health services. EPSDT dental services were a part of this broad case. The Court held that the State had failed to provide equal access to physician (especially pediatric) services and had also violated the reasonable promptness requirement. With respect to dental services, the Court said the State's program was "not a model" but found only one federal violation: that the State did not establish a dental periodicity schedule after consultation with dentists.

**Outcome:** Periodicity schedules were amended. The State was ordered to pay physicians who see Medicaid patients at 100% of the Medicare rate and to conduct a study to determine if that rate is sufficient. The rates were raised in the summer of 2005. In mid-May 2006, the State's report suggested a rate reduction; however, the judge said the report lacked sufficient information and has maintained the rates pending further evidence.

## Oregon

*Gibson v. Concannon*, Civ. No. 94-6306-HO/TC (D. Ore.) (Amended complaint, Sept. 20, 1994)

**Background:** This complaint was filed on behalf of poor Oregonians who alleged they were unable to obtain timely or adequate dental care. While the State had obtained a federal waiver to operate an experimental Medicaid program, the plaintiffs argued that,

except for specifically waived Medicaid laws, the program has to operate within the existing framework of Medicaid laws and regulations. Thus, the plaintiffs alleged violations of provisions that were not waived: § 1396a(a)(1) (statewide), § a(a)(8) (reasonable promptness), § a(a)(30) (equal access), and § a(a)(37) (prompt and efficient claims payment).

Outcome: The case settled when the state agreed to: (a) increase payments and (b) establish a toll-free line to help beneficiaries locate a dentist.

## Pennsylvania

*Clark v. Richman*, 339 F.3d 631 (3d Cir. 2004) (Summary judgment granted in part and denied in part), *on remand*, No. 4:00-cv-1306 (M.D. Penn. Aug. 17, 2005) (judgment)

Background: A group of children and youth with disabilities claimed that the state Medicaid agency denied access to Medicaid-covered dental services, alleging violations: § 1396a(a)(8) (reasonable promptness), § 1396a(a)(30) (equal access), and § 1396a(a)(43) and § 1396d(r) (EPSDT).

Outcome: The Court allowed the plaintiffs to enforce the equal access and EPSDT requirements but it dismissed the claim under § 1396a(a)(8), finding that provision only guaranteed the right to reasonably prompt payment for services, not to the provision of services themselves.

After an eight-day trial on the remaining issues, the Court ruled in favor of the State, finding that the Medicaid beneficiaries had failed to prove violations of EPSDT and equal access. Among other things, the court held that the State had a proper periodicity schedule for screenings that had been formulated in consultation with the Pediatric Dental Association and the Academy of Pediatric Physicians; the State complied with the EPSDT informational requirements, evidenced by managed care organizations' compliance with the informing requirements in their contracts and the fact that the State mailed out informational letters, handbooks and brochures, made and fielded phone calls from recipients; and maintained a website with "a wealth of information." The Court said the testimony regarding a lack of access was too limited and only "tangentially related to EPSDT."

*Scott v. Snider*, No. 91-CV-7080 (E.D. Pa. Dec. 2, 1994) (Order and stipulation of settlement), *same case*, (E.D. Penn. Aug. 11, 1993) (Stipulated settlement) (requires EPSDT informing of Medicaid-eligible mothers and infants at birth and before the mother's discharge)

Background: This case challenged the lack of outpatient provider participation in the Medicaid program, including dental participation. Plaintiffs alleged numerous violations of the EPSDT requirements.

Outcome: This is one of the first cases dealing in depth with a Medicaid managed care delivery system. A number of provisions address decision making and approval processes within the managed care plans. The broad settlement included a number

of performance measures directly affecting dental care. The State agreed to the following measures:

- (a) attempt to maintain an 80% enrollment rate of Medicaid-eligible children;
- (b) increase to 80% the proportion of children and youth receiving periodic dental services;
- (c) by ages 8 and 14, 50% of enrolled children and youth will have receive protective sealants on the chewing surfaces of their molar teeth;
- (d) submit a budget request to increase fees for pediatric dental services to 70% of usual and customary charge (with final budget within the Governor's discretion); and
- (e) consultation with the Medical Care Advisory Committee on how to spend appropriated funds.

## Tennessee

*John B. v Menke*, No. 3-98-0168, 176 F. Supp. 2d 786 (M.D. Tenn. 2001), unpublished memorandum order (Oct. 22, 2004)

Background: This case involves a broad challenge to the failure of the State to provide Medicaid EPSDT services to children in managed care settings. Allegations regarding inadequate dental services were included in the complaint. A ruling from the Court held the State responsible for compliance with EPSDT, even when it delegates delivery to managed care organizations.

Outcome: The case was settled with an agreement whereby the State would implement an EPSDT plan that calls for, among other things, (a) improving outreach and informing of beneficiaries about EPSDT, (b) updating and implementing statewide periodicity schedules, and (c) realizing enhanced measures of performance (including more accurate reporting on the EPSDT reporting forms). Monitors are assessing the status of EPSDT. On May 30, 2006, they notified the Court that a proposed draft of the report would be submitted to the parties by September 30, 2006.

*Brittney W. v. Preferred Health Partnership of Tennessee and Commissioner Tennessee Department of Health*, No. 3-98-0759 (M.D. Tenn.) (Settlement agreement, November 1999)

Background: This case was filed on behalf of a child who could not find a pediatric dentist to treat her progressing dental care needs. The complaint named a health plan and the Medicaid Commissioner as defendants. The claims included: § 1396a(a)(8) (reasonable promptness), § 1396a(a)(3) (notice and fair hearing rights when claims are not acted on with reasonable promptness), §§ 1396a(a)(43), d(a)(4)(B), and d(r) (EPSDT), and a third party beneficiary contract claim (on the contract between the Medicaid agency and health plan).

Outcome: The case settled when the defendants acknowledged that the child was entitled to dental services and the health plan agreed to pay a named dentist for all of the child's pediatric dental care. The health plan also agreed to survey participating

dental providers periodically to assure that its dental network is adequate and to send enrollees a notification of the availability of dental services.

## Texas

*Frew v. Gilbert*, 540 U.S. 431 (2004), rev'g, 300 F.3d 530 (5th Cir. 2002) (regarding federal court's authority to enforce consent decrees), vacating, 109 F. Supp. 2d 579 (E.D. Tex. 2000), *same case*, 401 F. Supp. 2d 619 (E.D. Tex. 2005) (denying motion for relief from judgment)

Background: This class action case, filed on behalf of Medicaid-eligible children on September 1, 1993, challenges the lack of EPSDT program activities and services.

Outcome: In a Consent Decree (approved February 16, 1996), the State agreed, among other things, to undertake numerous outreach and informing steps, to work to increase provider participation, and to monitor EPSDT performance. On August 14, 2000, the district court held the State had fallen short of its promises and ordered the State to comply with the Decree. The State argued that the federal court lacked authority to enforce the Consent Decree against the State, but the Supreme Court disagreed.

Meanwhile the plaintiffs' filed an amended complaint, alleging violations of equal access, caused by the failure of the defendants to assure access to necessary dental services. The State filed a motion to obtain relief from the judgment. The motion was denied by the district court on August 22, 2005. The Court refused to dissolve the Decree with respect to the dental program, finding that:

- (a) the dental participation rates represented by the State on the uniform federal reporting form, Form 416, had over-reported participation and used different statistics over time, resulting in "apples to oranges" comparisons from year-to-year;
- (b) the State's comparison of dental participation rates of time in Texas and relative to other states was fatally flawed because, among other things, states initiated dental screening at different ages); and
- (c) the number of active dentists had "stagnated" while the number of Medicaid-eligible children was increasing.

*Mitchell v. Johnston*, 701 F. 2d 337 (5th Cir. 1983)

Background: The plaintiffs claimed that cutbacks in services, including dental services, violated Medicaid's EPSDT requirements.

Outcome: The State's planned cutbacks were enjoined. As a result, the State could not reduce the number of periodic check ups; limit dental services to emergency, urgent situations; or exclude certain dental services altogether (topical fluoride, fixed space maintainers, and partial dental appliances).

Note: Congress recognized *Mitchell* with approval in legislative history to 1989 amendments to the EPSDT provisions of the Medicaid Act. H. Rep. No. 101-247, 101st Cong. 1st Sess. at 399 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2125 (1989).

## West Virginia

\**Randolph v. Miller*, Civ. No. 2:91-0212 (S.D.W.Va.) (Settled and dismissed, Aug 7, 1992)

Background: This class action case, filed on behalf of Medicaid beneficiaries needing dental and other Medicaid services, challenged announced cut backs in Medicaid payment rates.

Outcome: The case settled when the State agreed to take a number of steps, including:

- (a) development of a Medicaid services delivery plan;
- (b) providing technical assistance to help clinics qualify as federally qualified health centers;
- (c) providing unduplicated counts of beneficiaries, by county, utilizing services;
- (d) develop a program to recruit providers to underserved areas, including loan forgiveness;
- (e) improving dental screening rates to 80% over time;
- (f) revision of dental periodicity schedules;
- (g) establishment of an advisory board to the Medicaid Secretary;
- (h) increasing payment rates on selected services; and
- (i) assuring that 90% of “clean” claims (those needing no additional information) would be paid within 30 days of receipt; 99%, within 90 days.